JEFFRIES, ERIC DATE: 02/07/2003 CHART: 20648 NEW

ENCOUNTER ID 158277
SERVICE PROVIDER NEWTON H. BULLARD, M.D.
BILLING PROVIDER NEWTON H. BULLARD, M
SUGGESTED LEVEL Comprehensive
SUGGESTED E/M CODE 99205

SS NUMBER 111-11-1111
BIRTHDATE 05/15/1961

SYS BP	DIA BP	RESP	PULSE	TEMP	WGT	HGT	O2	LMP
138	82		85		279	76.0		/ /

DIAGNOSTIC IMPRESSION..... Relative Risk/Morbidity:Low

1. [P] [780.79] MALAISE/FATIGUE

Coding: [Chronic/Active,Recurring,Unstable,Continuing,No Work Up/Management:Complex]

ENCOUNTER ASSESSMENT / PLAN:

Complicated medical patient with numerous problems The primary difficulty in which he has is a chronic myalgia and neuralgia. Unfortunately, there are no objective findings to support his complaints. The rather peculiar gait asymmetry is unusual. Additional neurodiagnostic testing is probably warranted based on the somewhat focal nature of the symptomatology.

CHIEF COMPLAINT:

MYALGIA

HISTORY OF PRESENT ILLNESS

Complicated medical patient with a four or five year history of progressive disability originally following or associated with a hepatitis B injection. Extensive record review completed. His current symptoms are primarily of diffuse pain. This is intermittent. Neuralgia like in quality. Episodes of acute fatigue occur with minimal activity. This also is intermittent. In addition to this he has symptoms of muscular cramping. There is no defined precipitating event although activity appears to be associated with this. Multiple consultation have been obtained from a variety of specialists. He has been treated with nonsteroidals, steroids, some type of sulfa agent, antidepressants, herbal medicines, holistic treatments, acupuncture. None of the interventions appear to have been effective. His premorbid personality was aggressive and he was apparently quite successful in business. Since the onset of injury to me has had progressive inability to work actively. In addition to this there have been some right-sided focal neurologic changes. All previous evaluations have failed to reveal a specific etiology other than possibly chronic fatigue/similar type illness. An upper respiratory infection preceded the initial symptomatology as well. Multiple laboratory studies as well as scans have been performed on the patient. Currently the only effective agent appears to be Neurontin. During the course of his evaluation a small thyroid carcinoma was detected and has been successfully removed.

ALLERGIES - NONE LISTED

NEW MEDICATIONS - Instructions Were Given To The Patient Concerning Dosage, Route, And Side Effects

LEVOXYL	.175 MG	QD

ACTIVE MEDICATIONS

LEVOXYL	.175 MG	QD

STOPPED MEDICATIONS - NONE

PAST MEDICAL HISTORY

chronic fatigue, carcinoma of the thyroid

FAMILY HISTORY

noncontributory

SOCIAL HISTORY

former banker, married, children

REVIEW OF SYSTEMS

____Constitutional Symptoms____ * The patient denies fever. See history of present illness

____Eyes____ * The patient denies visual difficulty at this time. The patient denies diplopia. The patient denies excessive tearing, irritation of the lids, eyebrows, or sclera. The patient denies a history of trauma or familial eye disease.

____Ears, Nose, Mouth, Throat____ * The patient denies difficulty with hearing at this time. There is no complaint of tinnitus. The patient denies drainage from the ear canals or pain. The patient denies vertigo.

* The patient denies frequent colds, nasal stuffiness, discharge, itching, a fever, nose bleeds or sinus problems. The patient denies changes in the sense of smell.

* The patient denies difficulty with the teeth or gums, bleeding gums, sore tongue, frequent sore throats, presistent horseness, or difficulty with chewing and swallowing. The patient denies disturbance in the sense of taste.

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____Cardiovascular____ * The patient denies a history of high blood pressure, rheumatic fever, heart murmur, chest pain, palpitations, dyspnea, orthopnia, nocturnal dyspnea, edema, prior EKG changes, or other cardiac testing. The patient denies any tight sensations in the chest, arms, or neck associated with exercise.

____Respiratory____ * The patient denies a history of cough, sputum, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, or pleurisy. The patient denies pain with inspiration, night sweats, or unusual difficulty with exercise.

____Gastro Intestinal____ * The patient denies trouble with swallowing, heartburn, appetite, vomiting, regurgitation, vomiting of blood, or indigestion. The patient indicates that the frequency of bowel movements is unchanged. There has been no rectal bleeding, constipation, or diarrhea. There has been no abdominal pain, food intolerance, and excessive gas. There is no history of jaundice, liver or gallbladder problems, or hepatitis.

____Musculoskeletal____ * See history of present illness.

____Skin / Breast____ * The patient denies rashes, lumps, sores, itching, dryness, color change, or changes in hair or nails. The patient denies lumps, pain or discomfort, nipple discharge or other abnormality of the breast.

____Neurological____ * The patient reports intermittent neuralgia like symptoms. Intermittent muscular cramping, some right-sided weakness, some confusion

____Psychiatric____ * The patient specifically denies psychiatric problems. He has undergone prior psychiatric evaluation.

____Endocrine____ * The patient has had prior thyroid surgery for thyroid carcinoma. No other symptoms to suggest endocrine disorder.

____Hematologic / Lymphatic____ * The patient denies a history of anemia, easy bruising or bleeding, past transfusions and possible transfusion reactions. The patient denies a history of frequent infections.

____Allergic / Immunologic____ * The patient denies a history of significant allergy other than possibly drug allergy as previously mentioned. The patient denies enlargement, tenderness, or other abnormality of the lymph nodes.

PHYSICAL EXAMINATION

____General____ Constitutional Symptoms

**Somewhat wide based gait. No evidence of overt muscular wasting. Hygiene appears to be normal.

____Eye____ * Inspection of the conjuctivae and eyelids reveals no evidence of abnormal injection or discharge.

____Neck____ * Examination of the neck shows no evidence of masses, asymmetry, or crepitus. The trachea is positioned in the midline.

* Examination of the thyroid shows no evidence of enlargement, tenderness, or mass. can history or prior thyroid surgery with possible thyroidectomy.

____Respiratory____ * An assessment of the patient's respiratory effort shows normal respiration without evidence of the use of accessory muscles. Diaphragmatic movement is normal. There is no evidence of intercostal retractions.

* Percussion of the patient's chest shows no evidence of dullness, flatness, or hyperresonance.

* Palpation of the chest reveals no abnormality.

* Auscultation of the patient's lungs reveals normal breath sounds in all lung fields. There is no evidence of abnormal advential sounds including rales or wheezes. There is no evidence of rub.

____Cardiovascular____ * Palpation of the patient's heart reveals no evidence of abnormal thrill. The point of maximum impulse shows no displacement and there is no abnomality of the size or character of the impulse.

* Auscultation of the patient's heart reveals no evidence of murmur, gallop, or abnormal heart sound.

* Examination of the carotid arteries including auscultation shows no evidence of bruit, abnormal amplitude, or abnormal pulsations.

* Examinations of the abdominal aorta shows no evidence of enlargement or bruit.

* Examination of femoral arteries reveals a normal pulse amplitude and no evidence of bruit.

* The pedal pulses are intact and symmetric.

* There is no evidence of edema and/or varicosities in the lower extremities.

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____Chest (Breasts)____ * Inspection of the patient's breasts shows no evidence of asymmetry or abnormal nipple discharge.
* Palpation of the breasts and axillae reveals no evidence of mass, lumps, or abnormal tenderness.
____Gastrointestinal____ * The examination of the patient's abdomen shows no evidence of mass or tenderness.
* The examination of the liver and spleen reveals no evidence of enlargement.
* Examination of the patient's abdomen for the presence of hernia reveals no evidence of umbilical or inguinal hernia.
____Musculoskeletal____ * The examination of the patient's gait a rather wide based gait. Body position and balance are normal.
* Inspection of the digits and nails shows no evidence of ischemia, inflammatory conditions, ischemia, infections, or clubbing.
* No discreet evidence of muscular wasting is present. There is no synovial thickening.
____Neurologic____ * The examination of the patient's cranial nerves reveals no evidence of abnormality.
* Examination of the deep tendon reflexes shows no abnormal reflexes. All examined reflexes are equal and symmetric in intensity.
____Psychiatric____ * An assessment of the patient's judgement and insight reveals no evidence of impairment.
* The mental status examination of the patient shows normal:
  * Orientation to time, place, and person.
  * Recent and remote memory.
  * Mood and affect.
____Lymphatic____ * Palpation of the lymph nodes in the neck reveals no abnormal masses or adenopathy.
* Palpation of the lymph nodes in the axillae reveals no abnormal masses or adenopathy.
* Palpation of the lymph nodes in the groin reveals no abnormal masses or adenopathy.
* There is no evidence of abnormal lymph nodes in any other location.
____Skin____ * There is no evidence of any abnormal rash, lesion, or ulcer on the examination of the patient's skin.
* Palpation of the skin and subcutaneous tissues reveals no evidence of induration, subcutaneous nodule, infection, or tenderness.

N. H. Bullard, MD

Signature_____
NEWTON H. BULLARD, M.D.

Reviewed And Concurred With_____

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